of Need determines whether the hospital applying for the loan meets certain eligibility requirements for the receipt of the FHA loan guarantee.

In the absence of Certificate of Need authority, a State is allowed to commission a feasibility study. In addition, the hospital is required to demonstrate that there is a reasonable State or local minimum licensing and operating standard in effect.

The Certificate of Need Program is established to control the number of hospital beds and expenditures. When the Federal Certificate of Need Program began, 49 States enacted legislation for its Certificate of Need Program. Louisiana was the only State that did not.

As a result of continuing Federal policies encouraging deregulation, Certificate of Need authority has sunsetted in some States. In fact, over the last 20 years, at least 18 States have repealed the Certificate of Need Programs.

My own State of California does not have a Certificate of Need process. Therefore, it is far more difficult for hospitals to secure FHA-insured financing.

□ 1215

Under this new legislation, California would be put on a level playing field with other States.

Even in States that have retained the Certificate of Need authority, some projects do not qualify. In States that do not have a Certificate of Need program, the relevant State agency often lacks the authority to commission alternative feasibility studies. The result of this is many States simply do not have access to this lower-cost FHA-insured financing.

In fact, of the 64 hospital mortgages FHA currently insures under this program, only four are located in non-Certificate of Need States. Obviously, the section 242 program must be changed so that FHA-insured financing is accessible to hospitals in all States.

H.R. 659 would give HUD the authority to establish a process for determining the need and feasibility for a hospital's proposed project, thus eliminating the requirement for States to provide a feasibility study where no Certificate of Need exists.

This is an important bill that makes the necessary changes to ensure that the section 242 program is a viable program for all States. Again, I urge my colleagues to support this legislation and ensure that FHA-insured financing is available in each State for the purpose of building new hospitals.

Mr. Speaker, I reserve the balance of my time.

Ms. WATERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 659; and I would like to thank the subcommittee chairman, the gentleman from Ohio (Mr. NEY), and our chairman of the committee, the gentleman from Ohio (Mr. OXLEY), for expediting this legislation, because it is certainly needed.

I stand in strong support because FHA insures hospitals certainly under the section 242 loan program. The funding year 2004 administration budget is requesting the authority to insure $700 million of such hospital loans in funding year 2004. Decade-old statutory language authorizing FHA-hospital loans requires as a condition of a loan a State certification that there is a need for the hospital, or if no State procedure exists for such a certification, the State must commission an independent study of market need and feasibility.

H.R. 659 addresses that concern that this Certificate of Need requirement makes it difficult, if not impossible, for hospitals in many States, including California, as was mentioned, to be eligible for FHA loans.

This bill replaces existing statutory requirements with one that simply requires the HUD Secretary to establish a means for determining need and feasibility for any hospitals applying for a loan, with a proviso that a hospital located in any State with an official procedure for determining need, that a Certificate of Need must follow that procedure.

So I think that it has been well stated that the need is there. There are so many States that are waiting on us to provide them the opportunity to have access to this insurance, and I would ask for an ''aye'' vote.

Mr. OXLEY. Mr. Speaker, I rise in strong support of H.R. 659, the Hospital Mortgage Insurance Act of 2003 and urge my colleagues support.

The Committee on Financial Services unanimously approved this legislation on February 13, 2003. H.R. 659 amends Section 242 of the National Housing Act to ensure that every state will be eligible for FHA insured financing to build new hospitals or renovation and updates existing hospitals. The version we are considering today includes an amendment that will make this legislation effective immediately.

Back in 1968, Congress enacted Section 242 in recognition that hospitals were in need of low cost financing in order to fund capital improvements such as additions and renovations to existing buildings, and in some cases to build new hospitals. In order to be eligible for the financing, the 1968 law required the hospital to obtain a certificate of need or to perform a feasibility study. However, over the years, as part of the effort to encourage deregulation, certificate of needs authority has sunset in some states.

H.R. 659 recognizes the fact that many states no longer have certificate of needs authority or the mechanisms in place for feasibility studies. It sets up a more simplified process for states to be eligible for the low-cost FHA insured financing.

H.R. 659 will help to assure that quality, affordable health care is more accessible to rural and urban American communities where conventional financing may not be readily available.

According to the Congressional Budget Office, enacting this legislation would result in $2 million to $3 million of additional collections each year, which will offset any additional costs associated with this change in the program.

I want to thank Housing Subcommittee Chair BOB NEY and Ranking Member MAXINE WATERS for their leadership on this important bill. Mr. Speaker, this is a good bill and I urge member's support.

Ms. WATERS. Mr. Speaker, I yield back the balance of my time.

Mr. GARY G. MILLER of California. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the motion offered by the gentleman from California (Mr. GARY G. MILLER) that the House suspend the rules and pass the bill, H.R. 659, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. GARY G. MILLER of California. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

## AUTOMATIC DEFIBRILLATION IN ADAM'S MEMORY ACT

Mr. SHIMKUS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 389) to authorize the use of certain grant funds to establish an information clearinghouse that provides information to increase public access to defibrillation in schools.

The Clerk read as follows:

H.R. 389

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Automatic Defibrillation in Adam's Memory Act''.

**SEC. 2. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**

Subsection (c) of section 312 of the Public Health Service Act (42 U.S.C. 244), as amended by Public Law 107–188, is amended—

(1) at the end of paragraph (5), by striking ''and'';

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

''(6) establish an information clearinghouse that provides information to increase public access to defibrillation in schools; and''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Illinois (Mr. SHIMKUS) and the gentleman from Louisiana (Mr. JOHN) each will control 20 minutes.

The Chair recognizes the gentleman from Illinois (Mr. SHIMKUS).

GENERAL LEAVE

Mr. SHIMKUS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material on H.R. 389.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. SHIMKUS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, what I have before me is an emergency external defibrillator, and that is the purpose of the bill we have on the floor as we speak. It is an incredible device that saves lives, and that is what this legislation is a means to address.

As one of the original co-sponsors of this bill and as a proud member of the Committee on Energy and Commerce, I would like to commend all of those who have worked to bring this legislation to the floor.

This is a training model of an AED, an acronym that stands for Automatic External Defibrillator. While the training device cannot save a life, AEDs can and have in every corner of the States. While many know about our Chicago airports which have lead the Nation establishing public access to defibrillation programs, I would like to tell you the story about Sean Morely. Sean is a 13-year-old boy from Buffalo Grove, Illinois, whose life was saved because of an AED. While playing baseball Sean was hit in the chest by a fastball. He went into sudden cardiac arrest, a condition where the victim's heart most commonly flutters in the chest, but does not provide the body with oxygenated blood. Within 10 minutes, there is nearly zero chance of saving a cardiac arrest victim's life. But Sean was lucky. A passing police officer from another district used the defibrillator in the trunk of his car to restore a normal heart beat for the young athlete.

It is important to realize that defibrillation is the only way to restart a sudden cardiac arrest victim's heart. Without that defibrillator, this story would have had a much different ending.

Stories like these have driven State governments to pass bills requiring AEDs in numerous locations. The Adam Act will help our local communities by setting up a national clearinghouse to provide schools with how-to and technical advice to set up public access defibrillation programs. It will ensure that schools have access to the appropriate training, successful fundraising techniques, and other logistics involved. This is particularly helpful to smaller school districts that do not have the local resources such as a major hospital that often exist in more urban areas.

The clearinghouse will also collect data on a large scale, an effort to allow for research with issues related to cardiac death in children and adolescents.

Over 200,000 Americans die each year of sudden cardiac arrest including children. The American Heart Association estimates that about 50,000 of these victims' lives could be saved each year with a strong chain of survival. The chain of survival includes an immediate call to 911, early CPR and defibrillation, and the arrival of early advanced life support.

Please do not think that your community does not need this type of assistance. Consider that the average emergency response time is about 12 minutes. That is 2 minutes after a cardiac arrest victim is beyond help. The small cost in supplying this technology to our schools will be returned in full and by the length of service of years to the community for each young life saved.

Mr. Speaker, I appreciate all my friends and colleagues who have worked on this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. JOHN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to thank the gentleman from Illinois (Mr. SHIMKUS) for this piece of legislation, and I also want to thank my distinguished colleague from California (Mrs. CAPPS) for being the prime sponsor of this very important piece of legislation, House Resolution 389, the Adam Act or the Auto Defibrillation in Adam's Memory Act. This is an important piece of legislation that will authorize the appropriation of resources to establish a much-needed clearinghouse providing information to increase public awareness to successful life-saving tools and programs.

Mr. Speaker, as we all know, heart disease is the single leading cause of death in America. This year alone over 1 million people will suffer from cardiac attacks, or coronary attacks. Over half of these people will die, and half of those will die before they reach the hospitals. Additionally, 60 percent of the heart-related deaths are due to cardiac arrest, and half of those occur in the patient before they can reach the hospital.

It is vitally important to ensure that victims of heart disease and cardiac arrest are able to receive immediate medical attention, first responders right at the site. The Adam Act will help enable Americans to recognize and respond to incidences of heart disease and cardiac arrest by providing schools with the guidance and resources necessary to set up public access defibrillation programs. H.R. 389 will work to ensure that schools have access to the appropriate training, fundraising techniques and other logistical requirements for successful life-saving programs. This is a very important and good bill, and I urge my colleagues to join me in supporting this important bill, a life-saving piece of legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. SHIMKUS. Mr. Speaker, I yield such time as he may consume to the gentleman from Louisiana (Mr. TAUZIN), chairman of the full committee.

Mr. TAUZIN. Mr. Speaker, let me congratulate the gentleman from Illinois (Mr. SHIMKUS) for this extraordinary bill. This is indeed a life saver. There are many things we do in this House that affect people's pocketbooks or the way in which we do business in this country or the way in which we live in our communities. This one saves lives. And when we have these important bills we ought to really be grateful to the authors who bring them forward and who gave so much time and attention to it, as the gentleman from Illinois (Mr. SHIMKUS) has done.

This bill, H.R. 389, the Automatic Defibrillation in Adam's Memory Act, is a simple clarification of a grant program authorized already by the Public Health Security and Bio-terrorism Response Act for States, Indian tribes and localities to develop and implement public access defibrillation programs. Because many schools also serve as community meeting places, several communities are considering placing the AEDs in their schools. In order to assist the schools interested in installing these AEDs, this bill clarifies that the public access defibrillation program grant dollars already authorized may also be used to establish information clearinghouses to assist in these efforts.

Automatic external defibrillators, AEDs, are widely used by emergency personnel and health professionals to assist individuals suffering from sudden cardiac arrest. The use of AEDs has proven effective to save lives when following the chain-of-survival plan developed by the American Heart Association, which includes an immediate call to 911, early CPR and defibrillation, and early advanced life support.

Heart disease is the leading cause of death in this country. AEDs have proven helpful in reducing the number of cardiac arrest fatalities and expanding the use of these medical devices will undeniably help save more lives.

Again, I want to thank the gentleman from Illinois (Mr. SHIMKUS) and my friend, the gentleman from Louisiana (Mr. JOHN), for all the work our committee did in a bipartisan fashion to bring this bill forward.

The gentleman from Louisiana (Mr. JOHN) may not remember this, but when Dudley LeBlanc was a senator in the State senate in Louisiana, I watched as he suffered a massive cardiac arrest in the house chamber. And I watched as a defibrillation team came in and saved his life in front of all the other members, a dramatic, if you will, example of how this technology can really save lives.

Again, I thank both the gentlemen, but also to all the members of the Committee on Energy and Commerce for the great work they have done in bringing this bill forward. I urge my colleagues in the House to adopt it expeditiously.

Mr. JOHN. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. CAPPS), a prime sponsor of this life-saving piece of legislation.

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding me time.

Mr. Speaker, I am so pleased to rise in support of H.R. 389, the Automatic Defibrillation in Adam's Memory Act.

As co-chair of the Congressional Heart and Stroke Coalition and Caucus, I was proud to join with the gentleman from Illinois (Mr. SHIMKUS) in introducing this bill last year and again this year. And I want to thank my colleague from Illinois for his leadership on this issue. For the last few years, Congress has passed several bills to expand the use of automatic external defibrillators, or AEDs.

We have provided protections for good Samaritans, encouraged State and local governments to place AEDs in their buildings, and provided funds for their communities to purchase these devices.

The gentleman from Florida (Mr. STEARNS) and I have recently been urging the Architect of the Capitol to acquire AEDs and place them around the grounds.

□ 1230

We hope we will see movement on this very soon, and now, with this legislation before us, we are starting to get them into schools. Some have suggested that AEDs will become as prevalent as fire extinguishers. We can only hope so. Rescue professionals know firsthand their cost effectiveness.

This bill would create a national clearinghouse of information about AEDs and public defibrillation so that schools can begin placing them throughout their facilities. We do not usually think of children at school as being a high risk group for heart attack, but it has been known to happen, and schools, let us keep in mind, often serve as community meeting places where the public can gather at various events. Think of the times when schools are used as disaster centers. Add to this the parents, teachers and staff at the schools, and it only makes sense to be assured that they have the life saving devices such as AEDs available.

I urge my colleagues to support this bill.

Mr. JOHN. Mr. Speaker, we have no further speakers, and I yield back my time.

Mr. SHIMKUS. Mr. Speaker, I yield myself such time as I may consume.

I, too, want to mention the support from my colleague who just spoke, the gentlewoman from California (Mrs. CAPPS), who has really become a champion on a lot of health care-related items, and so when we get her on our team that is a good teammate to have, and I do appreciate that.

There is a health care crisis in America. There is a health care crisis in rural America. I think the point that 10 minutes, the response time being 12 minutes for the response time from most paramedics, 10 minutes is too short of a time. They cannot get there. That poses this need for this bill. That chain of survival, the E–911. We had the E–911 Caucus that helped us locate individuals, CPR, defibrillation and other life support measures.

This is an important bill and I appreciate the committee and my friends on the Democratic side for helping move this expeditiously to the floor. I ask my colleagues to support this bill.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the motion offered by the gentleman from Illinois (Mr. SHIMKUS) that the House suspend the rules and pass the bill, H.R. 389.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SHIMKUS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

## MOSQUITO ABATEMENT FOR SAFETY AND HEALTH ACT

Mr. TAUZIN. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 342) to authorize grants through the Centers for Disease Control and Prevention for mosquito control programs to prevent mosquito-borne diseases, and for other purposes.

The Clerk read as follows:

H.R. 342

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Mosquito Abatement for Safety and Health Act''.

**SEC. 2. GRANTS REGARDING PREVENTION OF MOSQUITO-BORNE DISEASES.**

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by section 4 of Public Law 107–84 and section 312 of Public Law 107–188, is amended—

(1) by transferring section 317R from the current placement of the section and inserting the section after section 317Q; and

(2) by inserting after section 317R (as so transferred) the following section:

**''SEC. 317S. MOSQUITO-BORNE DISEASES; COORDINATION GRANTS TO STATES; ASSESSMENT AND CONTROL GRANTS TO POLITICAL SUBDIVISIONS.**

''(a) COORDINATION GRANTS TO STATES; ASSESSMENT GRANTS TO POLITICAL SUBDIVISIONS.—

''(1) IN GENERAL.—With respect to mosquito control programs to prevent and control mosquito-borne diseases (referred to in this section as 'control programs'), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States for the purpose of—

''(A) coordinating control programs in the State involved; and

''(B) assisting such State in making grants to political subdivisions of the State to conduct assessments to determine the immediate needs in such subdivisions for control programs, and to develop, on the basis of such assessments, plans for carrying out control programs in the subdivisions.

''(2) PREFERENCE IN MAKING GRANTS.—In making grants under paragraph (1), the Secretary shall give preference to States that have one or more political subdivisions with an incidence or prevalence of mosquito-borne disease, or a population of infected mosquitoes, that is substantial relative to political subdivisions in other States.

''(3) CERTAIN REQUIREMENTS.—A grant may be made under paragraph (1) only if—

''(A) the State involved has developed, or agrees to develop, a plan for coordinating control programs in the State, and the plan takes into account any assessments or plans described in subsection (b)(3) that have been conducted or developed, respectively, by political subdivisions in the State;

''(B) in developing such plan, the State consulted or will consult (as the case may be under subparagraph (A)) with political subdivisions in the State that are carrying out or planning to carry out control programs;

''(C) the State agrees to monitor control programs in the State in order to ensure that the programs are carried out in accordance with such plan, with priority given to coordination of control programs in political subdivisions described in paragraph (2) that are contiguous;

''(D) the State agrees that the State will make grants to political subdivisions as described in paragraph (1)(B), and that such a grant will not exceed $10,000; and

''(E) the State agrees that the grant will be used to supplement, and not supplant, State and local funds available for the purpose described in paragraph (1).

''(4) REPORTS TO SECRETARY.—A grant may be made under paragraph (1) only if the State involved agrees that, promptly after the end of the fiscal year for which the grant is made, the State will submit to the Secretary a report that—

''(A) describes the activities of the State under the grant; and

''(B) contains an evaluation of whether the control programs of political subdivisions in the State were effectively coordinated with each other, which evaluation takes into account any reports that the State received under subsection (b)(5) from such subdivisions.

''(5) AMOUNT OF GRANT; NUMBER OF GRANTS.—A State may not receive more than one grant under paragraph (1).

''(b) PREVENTION AND CONTROL GRANTS TO POLITICAL SUBDIVISIONS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to political subdivisions of States for the operation of control programs.

''(2) PREFERENCE IN MAKING GRANTS.—In making grants under paragraph (1), the Secretary shall give preference to political subdivisions that—

''(A) have an incidence or prevalence of mosquito-borne disease, or a population of infected mosquitoes, that is substantial relative to other political subdivisions;

''(B) demonstrate to the Secretary that the political subdivisions will, if appropriate to the mosquito circumstances involved, effectively coordinate the activities of the control programs with contiguous political subdivisions;

''(C) demonstrate to the Secretary (directly or through State officials) that the State in which the political subdivision is located has identified or will identify geographic areas in the State that have a significant need for control programs and will effectively coordinate such programs in such areas; and

''(D) are located in a State that has received a grant under subsection (a).